Governor Announces Director of Department of Public Health & Human Services

(HELENA) Governor Brian Schweitzer announced the new Director of the Department of Public Health and Human Services.

Joan Miles is " a very talented and experienced professional for one of the most important jobs in state government - a person who will work hard for the families of Montana, ensuring we always remember the last and the least and who will fulfill the critical mission of the Department of Public Health and Human Services. Joan Miles has been working in the field for years, she has the experience necessary for this demanding position," said Governor Schweitzer.

"I am honored to accept this position," said Miles. "Public health and human services are two of the most important areas of government service. They are interconnected and critical to the health and well being of people. I am committed to meeting the challenges in both arenas head on and working hard for the families across this state."

Joan Miles, Helena - Miles was a Lewis and Clark County Health Officer and Director of the Lewis and Clark City-County Health Department. She was responsible for oversight and implementation of all

county public health activities and services in Lewis and Clark County. Miles prior experience includes: working as a Law Clerk for the Montana Supreme Court, serving as a State Representative in the Montana House of Representatives, and serving as Supervisor of the Environmental Health Division at Lewis and Clark City-County Health Department. Miles is licensed to practice law in Montana and California. She is a current member of the National Association of City and County Health Officials, DPHHS Public Health Improvement Task Force and MACo Health and Human Services Committee. She also serves as the Montana Representative to the National Network of Public Health Institutes and is the Public Health Law Faculty Member at the Montana Public Health Training Institute. Miles has a bachelor's degree in medical technology from State University of New York at Albany, a master's degree in Environmental Studies from the University of Montana and a Juris Doctorate from the University of the Pacific.

Miles began her position with the Department on September 12, 2005.

DPHHS has a new Medical Officer

Dr. Steven Helgerson has been hired as the new chief medical officer for the Montana Department of Public Health and Human Services (DPHHS). Helgerson replaces Dr. Mike Spence, who retired at the end of last year.

Dr. Helgerson has worked for the U.S. Public Health Service, Indian Health Service, Centers for Disease Control and Prevention, Health Care Financing Administration, and state and local public health agencies. His experience and expertise in public health programming and epidemiology spans a wide range of issues, from infectious disease control to environmental health to chronic disease prevention.

Dr. Helgerson has held faculty appointments at the University of Washington, University of North Dakota, Yale University, and Oregon Health Sciences University. He earned his medical degree and master's degree in public health from the University of Washington.

Dr. Helgerson began his new job Aug. 1, 2005.

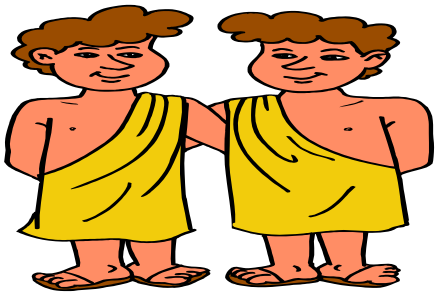
(Below) Dr. Steven Helgerson, DPHHS new Chief Medical Officer

The importance of de-duplication of the statewide hepatitis database.

In an effort to improve data quality, a new and up-graded hepatitis data bank program was put into operation several months ago. With the new system the hepatitis program numbers will represent a truer picture of hepatitis B and hepatitis C throughout the state.

It was discovered that there were close to 400 duplicate HCV entries into the previous database. This discovery decreased the number of reported HCV cases in Montana.

Another change involves the addition of Fort Harrison having its own "county". Previously Ft. Harrison's numbers were added to Lewis and Clark County. This gave Lewis and Clark County a false elevated caseload. Billings and Miles City VA test results will also go into Ft. Harrison's "county". Since the VA sees patients throughout Montana this seemed to be the only fair way to assign veterans, unless we know the actual county of residence for the veteran.



Pneumococcal vaccination an important part of hospital initiatives

- Joint Commission for Accreditation of Healthcare Organizations has listed PPV23 vaccination among the hospital and community acquired pneumonia core measures (www.jcaho.org).

- The American Hospital Association also has listed PPV23 vaccination as one of its core measures (www.cms.hhs.gov/quality/hospital/hqii.asp)

- Centers for Medicare and Medicaid Services (CMS) has endorsed PPV23 vaccination as one of its key hospital quality measures (www.cms.gov)

- The Hospital Quality Alliance (HQA): Improving Care Through Information provides information on the quality of care in hospitals that have volunteered to report their data for selected topics, including pneumococcal vaccination (www.cms.hhs.gov/quality/hospital)

In some areas of the U.S. up to 40% of invasive pneumococcal isolates are resistant to penicillin and other antibiotics.

Pneumococcal vaccine can be given any time of the year!

Stop in and exercise your brain!

"The Challenge" is presented for a little fun and we encourage you to discuss "The Challenge" with your peers and e-mail an answer to: thoran@mt.gov or fax your answer to the Immunization Program at 444-2920 to Tim Horan or, mail to: The Challenge, Immunization Program, Cogswell Building, P.O. Box 202951, Helena, MT 59620-2951

Winners will be acknowledged with Kudos in the next newsletter, and your names will be entered into a drawing for a T-shirt.

The Challenge - Last News Letter (Summer 2005, Vol. 11, No. 3)

Question: You come home from a business trip, excited to see your family, and when you walk in the door you hear the familiar bickering you've come to love so well. Your son and daughter are at it again, this time arguing over a vaccination question your daughter had on a final exam. Your son says, "Dad, say you have A 15 month-old child to which a clinic accidentally gives hepatitis B vaccine subcutaneously and MMR vaccine intramuscularly. The child needs to be revaccinated, right?" You carefully agree, but then your daughter chimes in, "Well, MMR vaccine is different than in the case of Hepatitis B." Your son jumps in with "they both have to be repeated, wing nut!" "Do not, you little twerp!" your daughter spits back. "The ACIP says differently!" You briefly consider heading back to the airport to find somewhere else to go, but then settle them both down to teach them a little vaccinology. What do you say?

Answer: Well, your daughter will have done well on her exam. Your son has a valid point too: the routes recommended by the manufacturer should always be adhered to, as data regarding safety and efficacy of alternate routes are limited. Administering a vaccine by the recommended route (into the appropriate tissue) promotes optimal vaccine safety and efficacy. However, your daughter has correctly stated that the ACIP (which strongly discourages variations from the recommended route, site, volume, or number of doses of any vaccine) recommends that vaccines given by the wrong route be counted as valid with **two exceptions: hepatitis B or rabies vaccine given by any route other than IM** must not be counted as valid and needs to be repeated. MMWR, February 8, 20002/ Vol. 51/ No. RR-2, pg. 13.

Much Kudos for the correct answer goes out to:

Rick Cottingham, Dept of Environmental Quality, Helena

Bridgett Kallenberger, Hill County Health Department, Havre

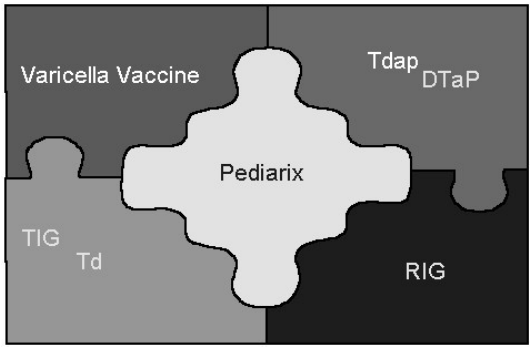
Kim Bowker (B.W. Richardson, MD; K.E. Lien, MD) of the Northern Montana Medical Group, Havre

T-shirts were given to all the winners.

New Challenge

New Question: On a beautiful spring day you come home to find your teenaged son and daughter arguing. This time they are arguing about, of all things, their healthy 65-year-old grandmother's (PPV23) first pneumococcal vaccination (Although they were, in fact, supposed to be raking the lawn). Your son contends that grandma needs a booster dose of PPV23, at least once, after 5-years to boost her immunity but your daughter says, "no way, and I can prove it!" your son challenges her to do so. Can she?

"PUZZLES" OF THE MONTH



Situation 1: Orders received on a 6-month-old child with factor 9 hemophilia recommend that all immunizations be administered SQ so that the child can be monitored for bleeding as the bleed from a SQ injection can be observed more easily than bleeding in a muscle.

Question: Is it appropriate for this child to receive DTaP, HIB and HepB vaccines SQ?

Answer: This issue is discussed in the ACIP General recommendations, http://www.cdc.gov/mmwr/PDF/rr/rr5102.pdf. Page 23. When IM vaccine(s) are indicated for a person with a bleeding disorder, or on anti-coagulant therapy, the vaccine(s) should be administered IM. *It is ultimately the physician's decision about the safety of the route for this particular patient.* If the patient receives antihemophilia or similar therapy, IM vaccinations can be scheduled shortly after therapy. The ACIP General Recs do not specifically address what to do if IM injections are administered SQ, but it is indirectly addressed in the recommendation that only **HepB & Rabies vaccines** *given by anything other than the IM route should be repeated, pages 13-14.* The recommendations on page 23 apply specifically to the situation described above.

Situation 2: On administration of Prevnar to a 4-month-old, a loose hub on the syringe results in ½ of the dose not entering the child.

Question: Does the dose need to be repeated, and what would the interval be?

Answer: The dose should be repeated as soon as possible. The only waiting time would possibly be between repeating doses of live vaccines.

Situation 3: A child being assessed for vaccine coverage is found to have received DTaP4 less than 6 months after receiving DTap3.

Question: Does the 4th dose need to be repeated?

Answer: The minimum interval between DTaP3 and DTaP4 is recommended to be ↕ 6 months. However, DTaP4 does not need to be repeated if administered ↕ 4 months after DTaP3. According to: ACIP General recommendations, February 8, 2002/ Vol. 51/ No. RR-2. Footnotes to Table 1.

Situation 4: A 12-month-old child has developed fever and a rash 7 days post-vaccination with MMR.

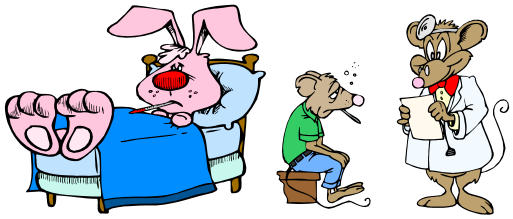
Question: If this is a manifestation of the replication of attenuated measles virus? Is this child infectious?

Answer: This is certainly an indication of a successful vaccine response and, if so, the child would be non-infectious for measles.

Employee Survey

Between December 10-13, 2004 CARAVAN® Opinion Research Corporation conducted a telephone Omnibus survey. A national sample of 1,039 adults (524 men and 515 women age 18 or older) living in private households participated. Below are the results of the survey.

- **75% responded their company encourages employees to stay home when sick, yet 38% feel pressured to come to work despite their illness**
- **59% are not hesitant about going to work, even though a co-worker is sick, while four out of 10 have gotten the flu from a sick co-worker**
- **34% say that "annoyed" best describes their sentiments when co-workers come to work sick, while 55% say they are sympathetic**
- **37% are sometimes unsure if they have a cold or the flu when sick**
- **55% said they have eaten chicken soup to treat the flu, yet only 16% said that they have used antiviral medicine to treat the flu**
- **34% said they have taken an antibiotic to treat the flu**



Value of Registry noted in aftermath of Hurricane Katrina

From the CDC Director's Emergency Operations Center P.M. Update,
September 16, 2005

Immunization Registries Help Children Avoid Extra Shots:

In Louisiana, Mississippi, and Alabama, many people who had to evacuate lost not only homes and possessions but personal records such as their children's shot records. Whether some kids are up-to-date on their shots or need a vaccination is being answered through existing immunization information systems. In Louisiana alone, CDC estimated that more than 8,300 queries were made to the Louisiana Immunization Network for Kids Statewide (LINKS) regarding vaccination histories for children who were evacuated. LINKS remains functional because a backup system located in Baton Rouge has been operational since Katrina struck.

An Alabama Department of Public Health professional, spent the day in an Evacuation Center. When she asked one mother with seven children whether she had any immunization records, the mother said she had nothing. Using the LINKS system, the public health professional found records on six of the seven children. The mother exclaimed, "We have proof that we are real people!"

Thousands of young evacuees throughout the United States have benefited from LINKS by gaining access to their immunization records electronically. Although special provisions are being made to accept students without proof of immunization into their new schools, having an immunization record provides extra assurance that no delays will occur, and no immunizations will be repeated unnecessarily. CDC recommends that children be vaccinated again if records do not exist. CDC estimates that 83 percent of the immunization history queries made to LINKS have been from Texas.

"Immunization: You Call the Shots"

Module 2:

Diphtheria, Tetanus, Pertussis

The National Immunization Program, CDC, announces the release of "Diphtheria, Tetanus, Pertussis," the second of 13 proposed modules for the web-based course, *Immunization: You Call the Shots*. This module includes descriptions of diphtheria, tetanus, and Pertussis; information on the vaccines to protect against these diseases; and recommendations for vaccine use. Extra learning opportunities, self-test practice questions, reference and resource materials, and an extensive glossary are all provided in an attractive, easy-to-use format.

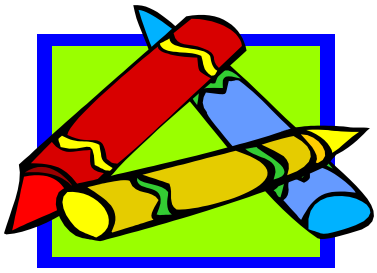
This module does not, however, include a discussion of the new diphtheria and tetanus toxoid-acellular pertussis (Tdap) vaccines for adolescents and adults. Information on these vaccines will be included at a later date, after publication of Tdap recommendations by the Advisory Committee on Immunization Practices (ACIP).

Immunization: You Call the Shots is an interactive, self-study course that participants can complete at their own pace. It is intended for introductory training of healthcare professionals who provide immunizations and can serve as a reference for all immunization providers. The audience may include nurses, nursing students, medical assistants, pharmacists, and other health professionals who provide immunizations. The purpose of the course is to improve immunization practice in the United States by increasing healthcare professionals' knowledge of immunization principles, use of the routinely recommended vaccines, and proper vaccine administration practices.

The course is available free of charge on the National Immunization Program website at: http://www.cdc.gov/nip/ed/youcalltheshots.htm. Physicians, nurses, health educators, pharmacists, and other healthcare professionals are invited to apply for continuing education credits.

Immunization: You Call the Shots was developed through a Cooperative Agreement between the National Immunization Program and the Association of Teachers of Preventive Medicine. Questions or comments about "Diphtheria, Tetanus, Pertussis" may be e-mailed to nipinfo@cdc.gov.

We could learn a lot from crayons. Some are sharp, some are pretty and some are dull. Some have weird names, and all are different colors, but they all live in the same box.



VFC Influenza Vaccine

Influenza vaccine has started to trickle into the HOME IV Pharmacy. At press time, the Montana Immunization Program has not received any preservative-free infant syringes. Although, we realize that CDC has included children 6-23 months as a priority tier for influenza vaccine, we would like providers to wait for their shipments of preservative-free vaccine to immunize these children. During the 2004-2005 influenza vaccine season, many infants were immunized with vaccine from the preservative-containing multidose vials before the infant syringes were available. As a consequence, many preservative-free infant syringes went unused nationwide at the end of the season.

Infants do not always mix well in mass clinics with adults, because infants are often due for other vaccines during flu season and can benefit from receiving doses of other vaccines during the same visit. Infants may also need more than one dose of influenza vaccine during a season based on their vaccine history, so there is benefit in recording those influenza doses in the immunization registry or having their immunization history handy for examination.

As reported in the last "Immune Response" we plan to provide influenza vaccine for all VFC-eligible children aged 6 months to 18 years. Therefore Medicaid will not pay for any children's flu vaccine given during the 2005-2006 season. Medicaid will continue to pay an administration fee.

As soon as we have sufficient influenza stock available to ship we will send a letter with ordering instructions and an order blank. (CDC assures us that preservative-free syringes will begin shipment within the next several weeks.)

Starting in 2006, the Immunization Program Health Educators will be including varicella vaccine in the up-to-date series measured during clinic reviews. The series measure 4:3:1:3:3:1 (76.0% in 2004) will consist of measuring the number of children who have received the following number of doses of the following vaccines: 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 HepB, and 1 Varicella. This measure will be used to evaluate progress toward the Healthy People 2010 goal of 80% series complete. As of 2005, varicella vaccination will have been recommended for universal administration for 5 years.

Missed shots-the toll of adult vaccine neglect.

Each year close to 40,000 Americans die of diseases that could have been prevented by routine adult immunizations. While we have near universal child immunization, adult immunization has remained in near fatal neglect.

The diseases that could be prevented by adult immunizations rival or outweigh higher –profile causes of death in the US:

- Traffic accidents 41,000
- Vaccine preventable disease 38,000
- Suicides 30,000
- Murders 17,000
- AIDS 13,000
- Fire/arms 8,000

(Source, CDC and Consumer Reports, vaccine preventable diseases include influenza, pneumococcal and hepatitis)

Vaccine Barriers

A 1996 CDC survey of Medicare recipients who hadn't received pneumococcal or influenza vaccines found that the main reason for not getting the shots was lack of awareness. A little over half the people who did not receive a pneumococcal shot said they had no idea they needed it.

Whereas there are well baby checks for those under two years of age, most adults don't make routine preventive-care visits to doctors. Most adults seek medical care only when injured or sick and vaccination is the furthest thing on their mind.

According to Dr. William Schaffner, chairman of the department of preventive medicine at Vanderbilt University " even most physicians don't realize that the vast majority of vaccine-preventable diseases and deaths occur in adults, not children".

James Singleton, acting chief of the adult vaccine-preventable disease branch of the National Immunization Program at CDC in 2001 said, " Your dog's veterinarian and your auto mechanic probably do a better job of reminding you about preventive maintenance than you doctor does."

Pneumococcus: Triple Threat

Pneumococcal disease can cause pneumonia, pneumococcal bacteremia and pneumococcal meningitis. In a 1998 survey only a mere 15 percent of high-risk adults ages 18-64 had received a pneumococcal immunization.

Dr. Gregory Poland, director of vaccine research at the Mayo Clinic in Rochester, Minn, shows a picture of a 39-year-old single mother who had her spleen removed (this placed the mother as a strong candidate for the PPV23 vaccine). Despite her multiple encounters with different health care providers, she never received a PPV23 immunization. She ended up with quadruple amputations from a pneumococcal bacteremia infection.

Opportunities to vaccinate high-risk persons are missed both at the time of hospital discharge and during visits to clinicians offices. Data from the 2002 Behavorial Risk Factor Surveillance Survey (BRFSS) shows that > 65% of patients with severe pneumococcal disease had been hospitalized within the preceding 3-5 years but had not been immunized.

Healthy People 2010 Goals

The goals for adults ages 65 and older is 90 percent coverage against influenza and pneumococcal disease. For non-institutionalized high-risk adults ages 18-64 years, the coverage goal for the two vaccines is 60%.